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**"What is strange is that we don't have more children coming to us":
A habitography of child psychiatrists and scholastic pressure in
Kolkata, India**

Abstract

The mental health of Indian school children could be expected to be a major topic of research. More people below 15 years are living in India than in any other country in the world, and India has undergone rapid social, economic, and demographic changes that have greatly increased the pressures on children to do well in school. Yet there is a striking dearth of research in this field. In this article we present the first ever study focused on child psychiatrists in India. Based on long-term fieldwork and interviews with psychiatrists in the Kolkata metropolitan area, we present a habitography of how psychiatrists experience young people's problems. Child psychiatrists are greatly concerned about the nexus between heightened expectations of educational success and a rise of mental problems among young people. At the same time, they wonder why not many more children are coming to them with school-related complaints. To date, there is not enough research that could either confirm or disconfirm the psychiatrists' analysis of social changes, but some conclusions on the plausibility of their views can be drawn.

Keywords

India

child psychiatry

child and adolescent mental health

Kolkata

scholastic pressure

depression

psychopharmaceuticals

habitography

Research highlights

- Indian child psychiatrists flag up an enormous increase in time spent with structured learning and in parental expectations of success
- Potential relations between mental ill-being and schooling among Indian children have not yet been properly studied by social scientists
- A habitography of medical experts highlights both what they know and what needs to be explored further

A habitography of child psychiatrists

"What is strange is that we don't have more children coming to us," said child psychiatrist Dr. Mitra during an interview in his chamber in South-West Kolkata. He thought it was "strange" that the intense educational drilling that children have to endure did not lead to even more children coming with attention deficit disorder, anxiety, suicidality, or depression: "We have seen an absolute rise of depression in younger patients. Where was this stress twenty or thirty years ago? We didn't have this stress" (Dr. Mitra). This was not an isolated opinion, but a strong consensus among the small but growing community of psychiatrists who are specializing in children and adolescents: "The main complaint is scholastic performance," as another child psychiatrist, Dr. (Mrs.) Bannerjee, summarized what prompted parents to bring their children to them.

Initially we found the psychiatrists' insistence on schooling as a source of poor mental health surprising. Kolkata psychiatrists generally subscribe to an ahistorical neurobiology of the brain rather than to historical theories of socioeconomic change. Therefore they usually do not make pronouncements on epidemiological changes. For example, when asked if there was an absolute rise of mental illnesses, Kolkata psychiatrists commonly point to the absence of "proper statistics" to either prove or disprove any epidemiological relations (Ecks 2008; 2013). Psychiatrists often mentioned social and economic transformations as causes for psychopathogenesis, but if probed, they abstained from conclusive

statements. If more patients come to psychiatrists, this would be attributed first to "greater awareness" or "less stigmatization," than to greater needs. In the same vein, psychiatrists put great faith in the efficacy of psychopharmaceuticals. Consultations tend to be focused on finding the best selection, dosage, and combination of drugs for the symptoms presented, rather than on figuring out what caused the symptoms. Generic versions of selective serotonin reuptake inhibitors (e.g., Prozac), norepinephrine reuptake inhibitors (e.g., Strattera) and psychostimulants such as Ritalin, are widely available and are routinely prescribed in India. Even when psychiatrists sometimes distance themselves from any "simplistic belief in the pill" (Dr. Chakrabarti), they never doubted that pharmaceuticals are the first-line treatment even for problems that were triggered by social or interpersonal relations.

Seeing a rise of mental illnesses among children and attributing it to scholastic pressures was an exception to this rule. Some psychiatrists thought that today's school stress lead directly to mental illnesses, others were more cautious and said that excessive learning exacerbated pre-existing conditions. But all were certain that schooling pressures were to blame for an absolute rise in ill mental health problems. Their surprise was only about not seeing *even more* children with school-related problems. They also saw this as a problem that affected children and adolescents across all social classes in India and not as an isolated phenomenon among a small elite.

In this paper, we analyze how private-practice psychiatrists in the Indian

megacity Kolkata reflect on the nexus between stressful schooling and poor mental health in younger people, and put their experiences into a larger context. The question we ask is: how do child psychiatrists view social change, and how plausible are their social theories compared to how social scientists describe the lives of young people in India today?

This article is based on long-term fieldwork in Kolkata (formerly Calcutta). Key findings are drawn from semi-structured interviews and shadowing observation with 18 Kolkata psychiatrists. They had different training backgrounds but all of them had full certification and at least several years of clinical experience. Dr Mitra's biography can serve as typical: after his Bachelor at Calcutta Medical College, Dr. Mitra gained a specialization from two of India's leading centres of psychiatry: first a PG diploma from the National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore; then a two-year residency at the Central Institute of Psychiatry at Ranchi, from where he graduated with an MD in 1994. He then returned to Kolkata to set up his own practice and quickly specialized in children because of the great demand from parents.

Like Dr. Mitra, all the psychiatrists presented here are working in the private sector. They all practice in a variety of locations across the city, typically for a few hours in private hospitals, a few hours in their own offices, and some of them also for a few hours in charitable hospitals and organizations (Ecks 2013). The doctors interviewed are working for direct fee payments from patients,

independent from the structures of the public health sector. Their patients tend to be class-stratified according to the places where they were seeing them: more middle and upper-class patients in the private hospitals and their own offices, and more lower and middle-class patients in the charitable settings.

Kolkata psychiatrists form a small group of experts, hence a purposive sampling method was used to identify and contact relevant respondents. Our data analysis proceeded from interview transcripts and fieldwork notes. All personal names have been anonymized to protect respondents' privacy. We explained the study to respondents before the interviews and obtained informed consent. Prior ethics approval was obtained from the School of Social & Political Science, University of Edinburgh. To contextualize the fieldwork data, both authors also conducted a search on relevant news reporting and media representations of scholastic pressure and mental health problems in West Bengal and other Indian states between 2012 and 2014.

The kind of research presented here could be called "ethnographic," but we feel that a new term is necessary to capture its specificity. We propose calling it a "habitography" of medical experts. It is not easy to let go of the term "ethnography" because it is well-established and easily understood in the social sciences. Ethnography is both a method of collecting data and also the final product of the writing process. Originally, ethnographies were focused on the description (Greek *graphos*, "writing") of a particular group of people (*ethnos*) as they live in a particular place at a particular time. Ethnography always entails

moments of comparison (what is different about these people?) and moments of contextualization (e.g., why are people doing what they are doing?) (Sanjek 2010). "Methodology" and "theory" are inseparable, and good "ethnography" could also be called "ethnographic theory" and vice versa (see Da Col & Graeber 2011).

But the word ethnography also entails layers of meaning that are constraining. The most obvious constraint is that descriptions are meant to be made of delineated "ethnic" groups. This emphasis on *ethnos* does not reflect that most anthropologists are studying complex assemblages of people and things in several sites (e.g., Marcus 1995). This emphasis on "assemblages" is particularly strong in anthropologies of science, medicine, expertise, and evidence-making (e.g., Ong & Collier 2005; Engelke 2007; Fischer 2007; Latour 2005; Timmermans & Berg 2010). Anthropologists are still grappling to find a conceptual language for the matters of concern that only come into being through being both dispersed and connected beyond bounded human groups. To date, the word *ethnos* seems to be hanging on merely for want of a better alternative.

For a new notion of how medical anthropologists can study diseases as "enacted" across different sites and different kinds of experts, Annemarie Mol proposed the term "praxiography," which "locates knowledge primarily in activities, events, buildings, instruments, procedures, and so on" (Mol 2002: 32). Replacing *ethnos* with *praxis* is an extremely productive move, but practice still implies an emphasis of human agency over nonhuman agency: things may "act" but they do not "practice."

We want to propose a new term: habitography. "Habit" has a spectrum of meanings that are equally about humans and nonhumans, about interiority and exteriority, as well as about affecting and being affected. A "habit" is many things: a kind of dress, usually one that is characteristic of a particular group; a mental and bodily disposition; a physical appearance; and it is a posture or demeanour. It can be traced back to the Indo-European root **ghabh*, "to take, hold, have, give, receive," stemming from "hand/forearm." Related to this are "to dwell" (to inhabit, the habitat) and "to be able" or "make able again" (rehabilitate). Its primary meaning in English today, that of a routine pattern of behaving or feeling, signals extended temporality: prolonged and repeated patterns rather than one-off events.

An obvious reference point for "habitage" is Pierre Bourdieu's concept of "habitus," through which he captured the dialectics of durable, transposable dispositions and the "fields" that co-constitute them (1990: 53). Similar to Bourdieu, we are also interested in describing habits in order to make them explicit, which is the precondition for being able to denaturalize them and to make them open to reflection (Bourdieu and Wacquant 1992: 73). "Habitography" does not need to be tied to Bourdieu's theories about social capital, distinction, or symbolic violence. "Habit" is broader than "habitus."

The present habitography of Indian child psychiatrists focuses on how they perceive the world around them, rather than how they act upon it. This is, in the specific case that we present here, an effect of the *indirect* relation between

psychiatric practice and school pressure. The starting point is the psychiatrists' surprise at *not* seeing as many schoolchildren for mental problems than they would *expect*: "What is strange is that we do *not* have more children coming to us." This limits the scope for drawing on participant observation of their daily work habits and accentuates what they say in interviews.

Another challenge to our analysis in this particular case is that the psychiatrists reflect on social processes that are not within their domain of expertise. When the psychiatrists describe changes in educational habits, they describe processes that usually belong to the domain of the social sciences. This heightens a feature of expert interactions that Holmes and Marcus (2005) call "para-ethnographic," that is, social scientific knowledge that emerges *outside* of the disciplinary boundaries of the social sciences (Boyer 2008). One of our conclusions from speaking with child psychiatrists is that they probably know something about the social sphere that social scientists like us do not know yet. If we used the term "ethnography," we would have to add prefixes such as "para-" or "auto-" to bring out this mutual reflexivity. "Habitography," by contrast, already enfoldes reflexivity on the habitographer's own blind spots.

"Chided for poor marks, 14-year-old boy ends life"

Substantial research on child and adolescent psychiatry has been done by anthropologists and sociologists in western countries, especially the United States

and the United Kingdom (e.g., McKinney & Greenfield 2010; Singh 2003; Singh & Kelleher 2010; Anderson-Fye & Korbin 2011). However, to our knowledge, there are no in-depth studies of what biomedical child psychiatrists are doing in India. Indeed, psychiatry in general is a fairly neglected field. Recent studies on psychiatry include Sumeet Jain and Sushrut Jadhav's (2009) on the implementation of national mental health programs in government clinics in northern India; Murphy Halliburton's (2009) study on how psychiatric treatments are compared to ritual and traditional Ayurvedic treatments in Kerala; and works by Renu Addlakha (2008), Jocelyn Marrow (2013), and Sarah Pinto (2014) on gender and family relations in north Indian mental hospitals.

Scholarly articles by psychiatrists on relations between scholastic pressure and child/adolescent mental health in India are also sparse: "Studies on incidence of childhood mental disorders are extremely rare globally and there are none from India" (Malhotra et al. 2009: 101). Most studies by psychiatric researchers in India are on the epidemiology of disorders and the lack of dedicated services (Jena & Siddharta 2004; Patel et al. 2007; Shastri, Shastri, and Shastri 2010; Kumar & Talwar 2014). Possible links between "academic failure" and higher rates of mental illnesses are sometimes mentioned in passing but, to our knowledge, never explored (Patel et al. 2007: 2310). Even recent research done by psychiatrists on suicidal ideation among schoolchildren conducted *on school premises* does not mention links between scholastic pressure and suicidal ideation (Bhola et al. 2014).

The anthropological literature on education in India is far more substantial than that on psychiatry. Donner's (2005; 2006) ethnography of education in Kolkata have been particularly useful for our own analysis. Sancho (2012) explores the enormous pressures that secondary pupils in Kerala are exposed to. Lukose's (2009) studies gender roles, consumption aspirations and "development" ideologies among young students in a hostel in Kerala; Fuller and Narasimhan (2006) explore the lives of IT and engineering students; and the books by Jeffrey (2010) and Jeffrey, Jeffery and Jeffery (2008) discuss young Indians' thwarted hopes during their school years and after entering the job market.

Anthropological studies echo the works of educational scientists. Nita Kumar (2007: 45), for example, highlights the "double pain" of Indian school children who first suffer the "over-disciplining" in schools and later suffer seeing their hopes for a bright future disappointed. Yet as much as these scholars are acutely aware of the socioeconomic circumstances that weigh down young Indians' mental well-being, the nexus between psychiatry and schooling is not examined. Recent work on youth suicides in Kerala by Joceyln Chua (2011; 2012; 2013; 2014) talks about both adolescents and psychiatrists, but educational pressures are not identified as a salient problem.

This blind spot in the scholarly literature on education and mental health in India—which we only realized after listening to the child psychiatrists—is even more puzzling when it is juxtaposed to the intense interest in this topic in the popular media. Reports about pupils and students committing suicide after

being scolded by a teacher, after receiving bad examination results, or after failing to get entry into a competitive college degree are staple news stories. "Dropout commits suicide in school" (Times of India, 23 Feb 2012) reports that a boy in Howrah (Kolkata's twin city across the Hoogly river) hanged himself in his former school following an argument with his parents. "Chided for poor marks, 14-year-old boy ends life" (Times of India, 11 April 2012) relates the story of a schoolboy who hang himself at his home after being criticized by his parents for poor examination results. The news article "Suspension threat drove teens to suicide, say parents" (Times of India, 3 February 2012), blames a school principal for triggering a double suicide. As the article highlights, the two students were "top-rankers and were awarded medals only hours before" their suicides. The principal's threat to suspend them from the school because they had skipped a sports session is considered unnecessarily harsh. On 11 February 2012, a suicide by drowning of a 17-year-old boy from one of Kolkata's most expensive private schools was reported. The story also opens by underlining that he was "among the top-rankers in class." The police wanted to investigate this case further because a "top-ranker" would have no reason to commit suicide: "what is baffling them is that he didn't have any apparent motive to kill himself." In July 2012, an 11-year-old girl killed herself by jumping off the roof of her school near Kolkata. The teacher reported that the girl was caught cheating during a chemistry exam and made to start her paper again. She left the room, and ended her life. The girl's father blamed the teachers' excessive pressuring (NDTV, 26 July 2012).

The most prominent school suicide in Kolkata in the past years was 13-year-old Rouvanjit Rawla's in February 2010. A student of La Martiniere for Boys, an exclusive private school, Rouvanjit received a "mild caning" by the principal because he skipped a class session. Four days later, Rounvanjit hanged himself. What all the news stories emphasized was that Rouvanjit was a good student and, therefore, there was "no reason" that he should kill himself, except for the humiliation received from the teachers. The incident gained national attention, and a number of psychiatrists were interviewed. A psychiatrist, Dr. Sameer Malhotra, commented in a TV interview (RT 2010) that punishment for academic indiscipline could make "sensitive" children feel "very vulnerable." Rouvanjit's father started a campaign to bring the principal and three other teachers to justice and several organizations got behind the cause, among them the Indian government's National Commission for Protection of Child Rights (NCPCR). In 2012 the principal was acquitted of "abetment to suicide" but the campaign against excessive school discipline is continuing to this day.

This emphasis on the schooling/suicide nexus is also visible in how the media portray official crime statistics. In 2010, the National Crime Records Bureau (2010) reported that West Bengal had more suicides of children (up to 14 years) than any other state in India (480 in total) and that 412 suicides were due to "failure in examinations." An article in The Telegraph (Calcutta) of 3 January 2010 declared: "Clearly, in the early teen category, West Bengal is the suicide capital of India." This article also included the responses by a range of Kolkata child

psychiatrists. One of them, Dr. Rima Mukherjee, estimated that "70 percent" of all under-14s suicides were caused by "exam pressure." Reporting on conversations with parents, Dr. Mukherjee heard the parents of a failing students ask their child: "why don't you die?"

Whatever may be the true distribution of child/adolescent suicides in India, the perception supported by the media—and by the psychiatrists interviewed by them—is that such suicides are very common in West Bengal, and that academic failure is the main trigger. Basically, Kolkata child psychiatrists say the same about excessive school pressures what the popular media are saying. We now want to contextualize in greater detail what the child psychiatrists said about the schooling/mental health nexus.

"Actual stress is really more"

"When I was a child, it was shameful to admit having a private tutor, because then you were not doing well. Either you were a slacker or dumb" (Dr. Mitra). But now it had become a batch of honour to give children as much private tuition as possible, and to start as early as possible. Providing a "top-notch" education for one's child is a marker of good parenting in Kolkata. "Top-notch" means starting to learn as early as possible towards formal curricula. It means that parents are heavily involved in education. And it means a strong use of private tutors to supplement, or even to supplant, the teaching provisions during

nursery and school hours.

Bengal has long been a centre of learning, and educational aspiration is a hallmark of Bengali identity (Kupfer 2014). Kolkata has seventeen public universities, with Presidency College, founded in 1817, as one of its oldest. Education has been central to self-definitions of Bengalis since colonial times. Belonging to the educated *bhadralok* ("respectable people") was an aspiration since the nineteenth century (Bhattacharya 2005). Being educated is considered being authentically Bengali. Since scholastic expectations have so long been the epitome of social status and advancement, the current perceptions of excessive pressures appear to be genuinely recent.

For most children from middle and upper-class families, schooling starts from an early age, usually from age 1.5 years onwards. Before entry into a primary school, the better-off children attend private nurseries that are often called "Montessori" even if they do not follow the Montessori approach. Preschools are private businesses beyond government control. The key appeal of preschools is that they teach in English rather than Bengali. Making children learn English from the beginning of their lives is seen as an essential precondition for success. As Henrike Donner (2006) highlights in her ethnography of Kolkata early-year education, the children of well-off families are educated *as if* they were going to be economic migrants to North America and Europe in the future. More immediate, of course, is the progression of the children from preschool into a "good" primary school. Because the best primary and secondary schools are

invariably private English-language institutions, English preschooling is perceived by many parents as an unavoidable first step in a child's academic career. These preschools are also competitive, requiring entry tests. In Donner's sample of Kolkata middle-class children, absolutely all of them attended a preschool. To force children "to study" from an early age is seen as regrettable but necessary.

The routine use of private tutors for children in addition to preschool and onwards is a peculiar feature of education in India today. Private tuition is near-universal for children from richer families but is also used widely even by lower-class parents. And while private tuition used to be more common in the cities, it is now also a routine feature of education in rural areas. The Pratichi Trust, an NGO headed by Nobel Laureate Amartya Sen, conducted a longitudinal survey of how West Bengal parents and teachers see primary school education.

Introducing the report, Sen emphasizes that India is one of only a few countries in the world where early private tuition enjoys such prominence (2009: 13).

According to their survey results, 50% of children in West Bengal received private tuition. The *demand* for private tuition was even higher: In 2001-02, 62% of West Bengal parents said that that private tuition was "unavoidable." By 2008-09, private tuition was perceived as "unavoidable" by 78% of parents (Pratichi Trust 2009: 81). Those who believed that private tuition was "unavoidable" but did not send their children to tutors did so only because they could not afford it. These statistics on West Bengal may sound improbably high at first sight but are

completely consistent recent work on changes in educational trends elsewhere in India (e.g. Chua 2014; Sancho 2012).

Parents are also expected to spend much time helping their children with homework. The stronger the parental involvement, the higher are expectations for success. Working hard a child was a foolproof recipe, yet when this did not bring results, stress levels shot up: "Parents think that if they put in all they have and sit with him till 1am, then he will do well. But mostly that doesn't happen and that creates stress. So actual stress is really more" (Dr. Majumdar). The increased involvement of parents, especially of mothers, in education even produced a shift in kinship relations between wives and mothers-in-law. Traditionally, Bengali households are multigenerational and virilocal. The married woman moves into her husband's house and is expected to obey not only her husband but also her mother-in-law. Wives are charged with doing the household chores under the supervision of the mothers-in-law. A young wife had to be "cultured," but high achievement in formal education was not valued by the husband's family. But since wives are now more highly educated than their mothers-in-law, and since the stress to support children in their education is so intense, mothers-in-law are now more likely than earlier to take on the household chores in order to allow the mothers to spend as much time with the children as possible (Donner 2005).

The overloaded school curriculum is another reason to seek private tutoring. For example, in the first three years of primary school alone, children's

history lessons cover human evolution, the rise of imperialism and the history of colonialism, the two World Wars, as well as the political revolutions in India, America, England, France, Russia and China. Even for good students, private tuition is seen as the only way of keeping up with the heavy curriculum. As with preschooling, providing one's child with tuition is a sign of good childrearing.

In our interviews, psychiatrists in Kolkata criticized this overload of formal studying and a lack of unstructured playtime. The doctors commented on how demanding the days of school children are: they have to wake up at 6am. Some of them would have one or two hours of private tuition even before school starts at 8am. When they return from school at about 3pm, they start again with private tuition or homework after 4pm. Only "relaxed" parents would let their children play for one or two hours in the afternoon. Free play is often substituted by extra-curricular training in cricket, swimming, or musical instruments. After a snack around 6pm, it is back to studying until 10pm. Then the evening meal is served (eating late and right before bedtime is a common habit of Bengali households). The children then sleep for seven hours or often less than that. The psychiatrists said that sleep deprivation was a common trigger of mental ill-being among children.

As we have learned from talking to Kolkata school children over years of staying in the city, the daily grind gets even worse in the run-up to exams. Once a fifteen-year-old boy attending one of Kolkata's most selective private schools, St. Xavier's College, told one of us (CK) that he cuts down his night sleep to just two

hours: "Before exams, I study until 3am. I get up at 5am to have some time to continue, before I go to school," he said. To him, and to most other school children we talked to, just trying to do one's best was never enough: one had to be "top of the class." While Bengalis in general often say that you have to be among the best to have a chance of pursuing the best university degrees and that your chances of succeeding in life are otherwise slim, this was not the first thing the school children said in interviews. Rather, they argued that not being a "topper" meant letting down one's family or one's school. Education and professional success was not about realizing one's own dreams. Instead, children felt they represented larger groups whose expectations, values and "honour" were at stake.

Reliance on private tutors was seen as a phenomenon that has struck the current generation of children far more than the previous. As some of the psychiatrists pointed out, private tuition was not unheard of during their own childhood days, but it was only used if a child was not doing well in school and needed extra help that the parents could not provide. Specialized training for the entry tests for elite universities start earlier and earlier. Parents had standardized ideas about ideal career paths, and there was an "anxiety about the son being an engineer or a doctor, they have the superior type ideas" (Dr. Majumdar).

Coaching for success in the joint entry examinations (JEE) for elite universities like the Indian Institute of Technology (IIT) are offered for children aged ten and onwards. Newspapers interview the annual top students for medical, engineering and business school entry tests, and the students proudly

report how many hours of private tuition they received. Companies that offer structured tutorials advertise with the portraits of their top-ranking students. The psychiatrists worried that these private provisions were now so important that some students only attended schools to get familiar with the syllabus, while the "real work" waited for them in their tutorials.

The cocooning of children in an ambitious learning environment led, according to the psychiatrists, to a range of mental troubles. The children had no time for friends and especially no time for relations with the opposite sex. If it happened that a teenager had such intense amorous feelings that they could not focus on their studies anymore, parents brought their children and demanded that the doctors treated love as if it were a mental disease: "Then they fall in love, it's like an explosion. The parents go bonkers. They come and say: 'The child is in love. Treat him for love! He's wasting time'" (Dr Mitra).

"The parents are also stressed out"

The psychiatrists put some blame on the schools and on their overloaded curricula, but the main problem were parents' excessive expectations. To be sure, these heightened expectations were one of the key reasons for a rise of anxiety, depression, and other mental illnesses across the entire society: "Collective reduction in human tolerance, of one person tolerating another person, even the ability to tolerate frustration. People are not ready to accept that they cannot get

everything they want. The level of expectation is much above their ability" (Dr. Chakrabarti). Yet it was parents' excessive hopes for their children's future that presented a key pathology in Indian society today.

Relations between parents and children in India are described as closer than in Western countries (Kakar 2008). All the psychiatrists thought that bonds were deeper and life-long: "Here, there is a tremendous preoccupation. You could have a 60-year-old man who was very worried about his 35-year-old boy. To him, he is still a child. They foster this kind of dependence and any kind of independence in thinking is looked down on" (Dr. Majumdar).

The psychiatrists also pointed out how intense exposure to pan-Indian and Hollywood movies has transformed people's lives. Until well into the 1990s, TV set ownership was rare and almost all the programming came from the somber state channel *Doordarshan*. The liberalization of television broadcasting and a much easier affordability of TV sets led to an explosion of viewership. The Indian cable TV industry went from non-existent to become the world's third largest after China and the United States within just a few years (Deloitte 2011). Psychiatrists, like most people in India, share the view that TV can be blamed for generational rifts and a ruptured sense of future expectations. Bollywood films show characters living in gigantic houses, driving luxurious cars, and dancing around Swiss resorts. American media show non-traditional gender roles and intergenerational alienation. "There is a general level of discontentment. Indians used to be very fatalistic: 'It's all in our karma.' But now the younger people are

questioning that. Daughters now say to their mothers: 'I won't put up with the amount of shit that you put up with'" (Dr. Majumdar).

Another change that the psychiatrists highlighted was the increased participation of women in formal work. Women were now better educated than earlier and wanted to use what they had learned in formal jobs. Increased expectations of material wealth also made women work more. The less time that women in work could spend with their children, the more time the children had to spend with either their grandparents or with nannies. These *ayyas* usually come from the rural hinterlands, live in the same household, and are low-educated and low-paid. Neither grandparents nor *ayyas* were, according to the psychiatrists, able to take care of educationally pressured children as well as the parents. The grandparents had too little energy, and the *ayyas* had too little knowledge and education. This increased parental anxieties further. Over several years of research in Kolkata we have met many middle-class women who felt deeply guilty for going to work instead of looking after their children.

The most profound change was the demographic shift towards smaller families. Kolkata's middle-class parents now have fewer children than a generation ago, and having only one child is becoming normal. Lower birth rates come with increased pressure to have a boy as the firstborn child. The selective abortion of female fetuses is a well-known social ill in India (Jha & Kelser et al. 2011). Sex selection is also common in West Bengal. But high expectations are not only applied to boys, almost the same pressure to do well in school is put on girls.

As the psychiatrists pointed out, being an only child focuses all attention on them. Small families detected any possible learning difficulty earlier, and hence the threshold to contact a biomedical doctor had become much lower than before. To some extent, this was a positive development, but parental expectations are also seen as a cause of distress among children: "Small-sized families, they give lots of attention to the child. When they find that the child is not performing too well, they go to doctors. That distress is identified from an early age. But the parents are also stressed out" (Dr. Majumdar). The children's stress could sometimes be diagnosed directly as a reflection of the parents' stress.

High expectations and hermetic cocooning had become so normalized that parents did not even recognize the situation as unusual anymore. And children had internalized these expectations so deeply that they did not realize that educational pressures could be a source of mental problems. The logic is that all are cogs in the same machine. If a child had difficulties, the parents could always point to so many other children in the same batch who were coping perfectly well. The parents saw problems as an individual character defect that needed to be corrected. The psychiatrists also reported how parents regretted that they had to coax their children so much: "They don't enjoy it, but there is this complete helplessness. They feel that this is the way that things are functioning" (Dr. Mitra).

The responsibility for seeking medical help lay with the parents. They still tended to delay coming to psychiatrists rather than being too early. Kolkata

psychiatrists agreed that children and adolescents should be brought to them as early as possible. Ignoring problems and shunning doctors only made things worse. "Catch them young" and "nip it in the bud" were common expressions used by them. Awareness of mental health problems among parents had improved greatly, but still more could be done.

On the other side of the spectrum, there were also the so-called worried well parents, who dragged their child to a psychiatrist only because the child received average marks. One psychiatrist estimated that ten percent of all his cases were children whose only problem was overanxious parents: "They won't have much of a problem, so I send them away" (Dr. Kundu).

It was a common perception among the psychiatrists that mental illnesses "run in the family." Hence they said that it was a good idea to analyze the whole family if possible. If psychopharmaceuticals are prescribed to a child or adolescent, it happens that other family members are prescribed some drug, too. The dynamics of what Michael Oldani (2009) calls "phamilies" work across generations: it can be a child that first enters psychiatry and then brings the parents as well, or parents initiate the contact and the children follow suit. "Phamily therapy" entails selecting drugs that work across generations. If, for example, the mother of a child was successfully treated for depression with sertraline rather than fluoxetine, then a doctor was likely to choose sertraline as well, even though the treatment guidelines for children and adolescents recommended fluoxetine: "It runs in families ... If I would normally give

fluoxetine but I know from the family history that the mother responds well to sertraline, I will give sertraline. Because that's a sure shot, that's metabolism" (Dr. Bannerjee).

Conclusion

How plausible is it that Kolkata psychiatrists identify scholastic pressures as a key source of psychopathology among young people? It might be argued that the child psychiatrists only have a skewed perception of wider social changes and that their opinions should not be taken too seriously. They form a small subset of an already small number of medical specialists and their views might be unrepresentative. On the other hand, that the psychiatrists talk like the popular media could reflect that they know as little about the extent and limits of pupils' mental health as the journalists who interview them. They might overestimate the importance of scholastic pressures because they are specialized in children and adolescents. Because the doctors work in the private sector and live from the fees that the parents are paying out of their own pockets, it could be argued that they overestimate the importance of educational pressures and while underestimating the ill effects of social marginalization, of substance use, or of physical violence. Moreover, the influence of pharmaceutical marketing on treatment habits could be another reason that a "rise" of child/adolescent mental health problems appears to have occurred in the past 20 years: this is the same era when Indian

manufacturers started to market a glut of psychopharmaceuticals. Even if a few of the private practice psychiatrists in Kolkata may try to keep a critical distance from a "simplistic belief in pills," the lack of non-pharmacological treatment choices, as well as the financial rewards of high prescription volumes, makes this hard to maintain. The doctors' readiness to treat not only individual children but whole "phamilies" speaks to their faith in the safety and efficacy of the available medications.

The opposite could also be argued: that the psychiatrists' experiences of recent socioeconomic changes are acutely correct, and that there really is a rise of mental health problems among the young in India. Aspirations for social and economic advancement through educational achievement may have been in place for a long time among Bengalis, but have intensified over the past two decades. Economic changes related to globalization have increased the need for high educational success. Demographic trends towards having fewer children intensify parental expectations. The rise of private tutoring in India, which grips even lower-class people who had previously invested less money in their children's education than the middle classes, goes hand-in-hand with a culturally pervasive notion that life success can only be achieved through excellence in learning. Once all these trends align with shrinking life opportunities for those who are "merely average," success in examinations become a matter of life and death to both young people and their families. It is plausible that the relentless educational drilling of children, from a young age onwards, can lead to mental

disorders, especially if there are any pre-existing problems. Awareness of what symptoms of mental distress might be and how to seek help from biomedical doctors may not yet be on a level that the psychiatrists might desire, but it seems to be moving in this direction. Intense media attention to links between young people's mental health and scholastic pressures seem to spread awareness. To this extent, our findings from Kolkata seem to confirm what advocates of global mental health are highlighting for other countries of the global South as well: economic gains from higher educational achievement are increasing but they risk being "won at the cost of the mental health of young people" (Patel et al. 2007: 1310). Because of these developments, it would seem extremely "strange" that not more children are coming to psychiatrists than the many who already come.

All of these claims remain hypotheses for now. The insights presented here, on how Indian psychiatrists see the nexus between mental illness and scholastic pressures, need far more research than we are able to present at the moment. What our habitography of—and with—child psychiatrists shows clearly is that the dialogue between different sets of expertise can be fruitful. In the present case, we think that the biomedical experts are inhabiting a social problem that the social scientists have not discovered yet.

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